ARKANSAS

Dr. Andy Allison, Director, Arkansas Medicaid

- Arkansas uses a care management model, rather than managed care.
- Arkansas has a new payment improvement initiative. They are providing direct to consumer health care system reform and moving away from the fee for service (FFS) utilization rewarded system to a system that rewards outcomes.
- Medicaid spending has become unsustainable over the years. If changes are not made to the program, a 37 percent increase in state general fund contributions will be required. The Governor proposed to meet over half of this amount but there is still a cap.
- Arkansas wants a 2 percent reduction in the annual growth in Medicaid. They broke down the growth between 2007 and 2012. The program grew by $1 billion, all funds. Sixty-one percent of growth was from increased payments per beneficiary and the rest was from increases in enrollment. Most of the costs were from increased spending per person. Most of the growth due to increased enrollment was for the disabled and the aged. Almost none of the growth was from poverty level families and children. Two thirds of the growth came from increased spending per person.
- For patients, Arkansas has the broad aim of improving health, enhancing the patient experience, and enabling them to take some responsibility for themselves.
- Example: Arkansas pays a global fee to obstetricians for prenatal care and separate fees for the delivery (hospital, prescriptions, and other care related to pregnancy).
- For the developmentally disabled, Arkansas pays largely FFS and the individual will have multiple service providers. No one is responsible for coordinating and ensuring compliance of their medical care. Many of them are dually eligible for Medicare. Arkansas wants to change the system so that someone is responsible for the patient and their experience; however, Arkansas does not pay for this now. It pays for disaggregation not aggregation.
- For the developmental disabled population, long term care, and behavioral health, Arkansas will wrap its arms around payment for both the disabling condition and the responsibility (health home) to bridge the targeted treatments for the condition as well as responsibility for the patient's medical health. This is a population based payment mechanism. Arkansas received approval of a State Plan FFS adjustment.
- Example: the provider is at risk for the outcome of the pregnancy. Quality thresholds and requirements are attached, as well as positive and negative incentives with cost sharing or risk sharing. The obstetrician can share in gains with the state if he/she performs well for the total cost of pregnancy – even those that Medicaid does not reimburse to the obstetrician. For example, if the mother stays in the hospital for two or three days, whereas the statewide average for private pay is under two days, the obstetrician may owe Medicaid money even though Medicaid did not reimburse them for the hospital services and will

continue to reimburse the hospital for those days. But since the obstetrician must approve the additional days in the hospital, Medicaid holds them responsible. If the obstetrician is able to beat the historic average or bring the average length of stay down, Medicaid will give them half of the difference in that historic average and what they are able to achieve in a full year for all of their patients going forward. This means the obstetrician can now gain from efficiencies in reduced payments to the hospital.

- There is a dramatic shift in the way staff manages the program. Staff are no longer dealing only with prior authorizations but are now engaged in finding those episodes of medical care where there is an opportunity to improve performance and achieve efficiency. They are going through hours per episode to rewrite the payment standards.
- In summary, Arkansas is not in a commercial managed care market but they have put in place very strong metrics and started with certain specific diagnoses. They have set the criteria and pay based on whether people do better than expected or they have some risk, if there are big outliers.
- Arkansas has a team leader for all costs associated with a particular procedure. They will reimburse everyone as they do now but at the end, Arkansas will hold that one provider accountable and make the comparisons and the financial consequences to that one core provider. Basically, Arkansas pays FFS in real time and when outcomes and costs are reviewed, the team leader either shares gain or pays back dollars.
- For nursing home care and developmentally disabled, payments may be bundled.
- Arkansas sets the rates.
- Arkansas is finalizing plans to move dramatically toward statewide, full scale implementation of a patient centered medical home to care manage, which they do some of now. Arkansas has a $2 or $3 per member per month but the expectations are very low. In addition to the per member per month, Arkansas will also add substantial upside gain sharing possibilities for primary care if primary care is able to beat the trend in the growth of the total cost of care. The aim is to give primary care the opportunity to increase its reimbursement for Medicaid by 50 to 100 percent.
- Two critical components are to have a strong Medicaid staff to analyze the data and assist with implementation and the other is a very robust system to provide the data. Arkansas pays an outside vendor, McKenzie and Company, about $1.5 million a month, along with Blue Cross Blue Shield, for intellectual capital in the process.
- Reform should be designed to address growth and utilization. Arkansas has redefined how it pays. The next steps are to develop data capacity and run the numbers.
- The first payments were made on October 1 so it is too early to determine if provider risk sharing has a deterrent effect on the network. Arkansas has not heard of any obstetricians dropping out of the network. It pays for two-thirds of the births in the state. They have paid more in gain sharing than they have

recouped in risk sharing and so far, have not been required to make any regional adjustments.

- Consumer oversight mechanism – Arkansas has public workgroups, informal input, and open public meetings www.paymentinitiative.org explains this in great detail.
- Arkansas has 650,000 Medicaid members. The current growth rate per recipient is about 4 per capita and Arkansas is trying to reduce this to 2.
- Medicaid expenditures are around $5 billion. The match rate has fallen for 2014 to a little over 70 percent.
- Arkansas needs $1.5 billion in state match and only has $800 million currently. They are facing a reduction in the program but hope Medicaid expansion will alleviate the cuts.

CONNECTICUT

Kate McEvoy, Interim Director of Health Services, Connecticut Department of Social Services

- Connecticut had commercial managed care with three managed care organizations for the majority of coverage groups (not long term care) but moved to an administrative services organization (ASO).
- Managed care did not yield savings in the way it was conceptualized. Connecticut thought it would be more predictable in expenditures and cost containment.
- Challenges: It was difficult to get the type of encounter data they wanted. The degree to which plans were able to control costs was in question over time and was not consistent among the three managed care organizations (MCOs). They had a limited scope of measured performance and it was hard to gain comparability. There were also challenges with provider relations: there were distinct reimbursement rates with the three entities and the negotiation process was individual to each of the three, even where providers spanned geography that went beyond one provider. The for-profit administration of two of the plans was an issue in the rate negotiation process. Streamlining administration from the aspects of utilization management and member relations was an issue. It was difficult to get consistency across three entities.
- Two years ago, Connecticut assessed how they were doing and looked at costs; member experience; and the effect on provider enrollment, retention, and attrition.
- On January 1, 2012, Connecticut moved away from managed care and consolidated medical services across all populations and included long term care. Children, low income adults, family coverage, pregnant women, and long term care are under the auspices of one single streamlined ASO. The idea is to give them a streamlined administrative structure and enable them to gain consistency of application in terms of members, reports, and utilization management strategies, with a facilitated agenda to study performance measures, health outcomes, client satisfaction, and provider relations. And to permit them to focus on the high utilizers in the Medicaid population.
- All Medicaid beneficiaries are eligible for intensive care management. Connecticut is doing prior authorizations, concurrent reviews, and population based studies,
- Intensive care management lets them pull out individuals with the most complex health issues to work through the central structure of the ASO using a holistic, person centered, goal-directed, care planning tool that seeks to meet the individual with commitment to self management of conditions and managed through geographically organized teams who act as the single point of contact with other disciplines to work on the individuals total plan of care.
- Connecticut has an administrative fee withhold. They contract with the entity and pay them an administrative fee and withhold 7.5 percent of the fee annually. The

ASO can earn toward the 7.5 percent withhold by meeting identified performance measures.

- Connecticut has also implemented an ASO arrangement for behavioral health and dental services. They also centrally manage pharmacy services and plan to implement an ASO arrangement for non emergency medical transportation effective February 2013.
- The model provides the framework for how approaching the provision of services and building on this with a person centered medical home pilot that provides enhanced FFS payments and performance payments against the benchmarks.
- Connecticut has 575,000 Medicaid members; the total cost is $5.12 billion; the match is 50 percent; and the state share is $2.5 billion that is a General Fund appropriation.
- Last summer, Connecticut expanded to low income childless adults, aged 19-64, and they serve 83,000 under this population group.
- Connecticut provides services at 185 percent Federal Poverty Level in many categories.
- The contract is with a non profit entity who was one of the MCOs Connecticut previously worked with.
- Connecticut sets the provider rates (FFS, no capitation in any of the groups) and enrolls providers through an outside contractor).
- Providers are much happier in terms of bureaucratic interface but not with reimbursement – Connecticut reimburses overall at the .99 ratio, when Medicaid rates are compared to Medicare; however, this is heavily influenced by the fact that Connecticut pays very generous obstetrically, so for some services (such as physician services), Connecticut pays at about .59 against the Medicare rate.
- The annual growth rate of per member is not available.
- The ASO is the central point for member services; they perform all of the data functions; they are the liaison with the providers on utilization management, prior authorizations, and concurrent review; and is the technical assistance source to primary care practices that are pursuing patient centered medical homes.
- The stakeholders were very anti-managed care, so the ASO was embraced by the advocates.
- They have a statutorily constituted oversight body and workgroups.
- The ASO does not do gain or risk sharing with the providers. The savings are administrative. Connecticut wants to manage acute care costs, so they are reviewing service delivery strategies to reduce costs.
- Connecticut is seeking approval of a duals demonstration project to serve all dual populations and build on the North Carolina model. They propose a variant of the local systems of care model to create three to five patient health neighborhoods. They propose to serve all dual populations and build on the North Carolina model by incorporating a comprehensive multi-disciplinary array within the health neighborhood, bringing in medical and behavioral health providers, and also long term services and support. They propose to procure, through an RFP, three to five patient health neighborhoods and equip them with data from the ASO. They plan to provide start up payments to help support organization and contracting among the entities that are coming together, then

propose to pay a per member per month (PMPM) payment for care coordination and for some supplemental services that are not currently covered under the Medicaid State Plan (for example: falls prevention, nutrition counseling, and medication therapy management) as well as services that are specifically oriented to behavioral health. Connecticut will look under the auspices of the duals demonstration to engage in the sharing of any savings through performance measures that will be developed.

KENTUCKY

Contact: Lawrence Kissner, Commissioner, Cabinet for Health and Family Services, Department for Medicaid Services

- In March 2011, Kentucky's Governor decided to go to managed care to prevent a 30-35 percent reduction in provider reimbursement. A request for proposal was generated and contracts were awarded in July 2011, with an effective date of November 1, 2011.
- Kentucky has 825,000 Medicaid members - 700,000 are under managed care and 125,000 are in fee for service (FFS).
- Medicaid retroactively enrolls members.
- The budget is $6 billion, which is all in FMAP and state funds.
- The match rate is about 70 percent.
- Of the state share of $2 billion, about 75-80 percent comes from the state. The provider tax is capped and not all provider types are taxed. Medicaid uses intergovernmental transfers and rebates.
- They did not budget correctly – they were running the rebate for prescription drugs on 500,000 people and all of a sudden the rebates were only on 100,000 people. That was an impact that was not assumed in the budget.
- Between November 2011 and July 2014, Medicaid will save the state 1.3 billion total dollars ($400 million state savings), which is the amount needed to meet the biannual state budget.
- Medicaid projected a very moderate 1.2 or 1.3 percent growth rate in Medicaid, which was the average experienced over the last 4-5 years. The difference between the projection through 2014 and the managed care cost is $1.3 billion in savings.
- The FFS members cost $3 billion and the managed care costs the remaining $3 billion. The FFS members are a small that group that costs an awful lot of money.
- Managed care is not implemented in the long term care population. One third (and $1 billion) of the FFS members are in nursing homes. The other two thirds are in waiver programs – money follows the person, brain injury waivers, E/D waivers, prescription drugs, hospitals, physicians, adult day care, etc. Medicaid also has a capitated program to keep people out of the nursing home and pays for all institutional and non-institutional care. In a couple of years, Medicaid's focus will change to the other waiver programs and on how to maximize those. Medicaid has residents of mental institutions that they are trying to move to home and community based services.
- Those eligible for waiver programs that are in FFS are excluded from managed care. The managed care organizations (MCOs) can pay for nursing home care if it is needed as a step down from hospital admission and ultimately to home, if that is the logical progression.

- Kentucky has 8 regions, one of which has had managed care with one provider for 15-20 years. The other 7 regions had no managed care and were basically FFS. Medicaid accepted three managed care companies for the 7 regions.
- Two of the regions contained half of the population and the remaining regions were determined by historical definitions of regions and by using the existing structure. Kentucky has community mental health centers that operate in the same regions. There are 20 or 30 counties per region.
- Some services are only available in one or two regions of the state. Medicaid has network standards of 60 minutes and 60 miles and 45 minutes and 45 miles. If Medicaid had 6 cardiologists that were participating in a particular region under FFS, the MCOs were given a target to ensure network adequacy. If the MCO had one third of the members, they had to also have at least two cardiologists. The MCOs were not required to build the exact same network that Medicaid had but the network had to be commensurate with the membership. The MCOs provide Medicaid with their network and Medicaid compares the network to the membership. If the network is deficient, a corrective action plan must be done.
- Medicaid allowed the MCOs to develop their own rates, using a data book provided by Medicaid.
- Medicaid did not get involved in the provider reimbursement rate discussions but heard from the providers that they are not paid enough (Medicaid also heard this prior to the implementation of managed care).
- All provider types are included under managed care and there are no carve outs.
- At the beginning, Medicaid allowed the MCOs to have differences in benefits but at a minimum, they had to meet the Medicaid benefits. They also allowed the MCOs to provide richer benefits if they wanted. For example, if Medicaid charged a $1 copay for a prescription drug, the MCO could offer a $0 copay. This caused members to make decisions based on network differences and plan design differences. During the first annual open enrollment, which was November 1, 2012, all of the carriers changed their benefit design so that they all offer the same benefits.
- Some of the MCOs have capitated arrangements with some sub vendors, whether mental health or prescription drugs.
- The MCOs indicated their costs were more than anticipated and that they are losing money. One MCO decided to leave the state. Business was awarded to PassPort, Humana, Coventry, and WellCare.
- The contracts are for 32 months and the MCOs built in their own rate increases when the bids were submitted. On July 1, one carrier received a 1 percent increase and on October 1, two carriers received a 5 percent and a 3 percent increase. The contracts have four one year extensions with no price linked to them. MCOs can continue without bid for four additional years.
- The provider community was very vocal about managed care. Medicaid had not been as strict with prior authorizations, bouncing non emergency ER visits out of the hospitals and into doctors' offices, and with the number of days needed for hospital admissions. Managed care brought more discipline to hospital stays being appropriate for the condition or procedure. MCOs drove more people to primary care and out of ERs so the hospitals were impacted from the beginning

as people were channeled to appropriate and less costly forms of care. The advocates for brain injuries and the mentally challenged understood the value of good case management and were supportive.

- Physician issues were more due to the amount of time it took to get the network built and the contract signed than to rates and reimbursements. Medicaid allowed for the initial assignment of members and allowed letters of intent to be used as a pending deal but once managed care went live, actual contracts were required. There are constant changes in managed care. A provider may participate for 6 months and decide he/she no longer wants to participate so the contract is cancelled with the given vendor.
- Medicaid works with the 56 public health offices. Local health departments provide a number of school based services.
- The role of the Medicaid staff changed from paying bills to managing MCOs. Medicaid reviewed each contractual obligation and created dash boards. For example: the MCOs must answer the phone in 60 seconds or less and must have a less than 5 percent abandonment rate. The dashboard will either show green (under 60 seconds and under 5 percent) or red (more than 60 seconds and more than 5 percent). If the MCO is on red for one month, a discussion takes place; if they are on red for over two months, a corrective action plan is requested; and if the problem continues and the corrective action plan does not resolve the issue, the next step of discipline or the breach of contract process begins. Medicaid receives more than 100 different reports from each MCO monthly.
- Phone calls are outsourced; however, Medicaid's phone calls increased. When a member called about a problem with an MCO, Medicaid did not have any information to answer the question because they did not pay the claim, did not do the prior authorization, and did not know the medical history. This was not anticipated. Medicaid became a compliance monitoring organization.
- Medicaid created processes to direct callers to the appropriate person for assistance. Medicaid hired a peer review organization (which is a requirement with MCOs) to audit the MCOs. Also when Medicaid would transfer a caller, Medicaid would stay on the phone line to listen to the call and see how it was handled.
- In order to change to managed care, Medicaid filed state plan amendments and changed regulations. Readiness reviews were done to assess whether the MCOs were ready to pick up the membership. CMS was onsite and participated in the readiness reviews. A number of consultants were hired to assist and some were issue-specific, such as IT transformation. The entire process took about 4 months.
- One of Kentucky's regions fell under the 1115 waiver; the others were under the 1915B waiver.
- Since Medicaid had such a serious budget shortfall and needed to make a change quickly, transforming to existing managed care, as opposed to asking providers to build their own managed care network, was appropriate. All of the MCOs Medicaid deals with work in multiple states, they are able to find solutions,

which are very creative and outside of the box. If an MCO learns something in one state, they can bring it to the other states.

- Lessons learned – Medicaid implemented managed care fast and they do not recommend Alabama doing the same. Moving too quickly makes it difficult. Medicaid had to shift from FFS. They had contracts to pay someone to do claims processing, prescription drugs, prior authorizations, and case management. The volumes in these contracts dropped by 80 percent and yet in some instances they had a fixed cost contract. Phone calls dropped by 70 percent but the rate they were paying for the service did not drop at all. If Medicaid could have anticipated this, they would have changed earlier to a unit price rather than a fixed cost. Dividing the state into regions is a good idea and phasing the regions in over time would be preferable.
- They are seeing more preventative care, which is what they want to happen.

LOUISIANA

Contact: Ruth Kennedy, BAYOU Health Program Director, Louisiana Department of Health & Hospitals

- The Louisiana Department of Health & Hospitals (DHH) recently implemented commercial managed care and also has some community based managed care that is operating at the same time.
- DHH began drafting the request for proposal (RFP) for risk bearing plans in July 2010. The RFP was issued in April 2011, contracts were awarded in July 2011, and the MCOs went live February 2012. Their plan to go live in January 2012 was postponed due to a hurricane.
- Louisiana has 899,000 Medicaid members and is a $7.4 billion program.
- 899,000 are in Bayou Health and 100,000 are in nursing homes, home and community based waivers, and the Medicare dual eligible population.
- Medicaid does not retroactively enroll members.
- Medicaid is funded by nursing home provider tax, pharmacy provider tax, drug rebates, and supplemental rebates. There is no hospital provider tax. The match percentage paid by appropriations by the LA legislature was not available.
- Expected savings for MCOs is 3 percent and for the patient care case management models (PCCMs) is 1 percent. Savings are nominal on PCCM population. Net state savings are $40 million. For years 2-4, DHH does not expect savings to increase. The savings are realized up front and then maintained.
- The majority of Louisiana's Medicaid population are children and people with disabilities.
- Louisiana has a historic reliance on the FFS delivery model and has been working on transitioning from FFS to managed care or coordinated delivery models since February 2008. In 1997, Medicaid made the effort to implement a pilot in one of their 9 geographic regions. They received only one proposal so they waiting 10 years before looking at it again. In 2008, when there was no budget crisis, Medicaid looked at using a better Medicaid delivery model in conjunction with expanding Medicaid to parents as well as doing a pilot in one region for everyone. Then the state budget changed, so they did an 1115 demonstration waiver to pay for the modest Medicaid expansion through the changes to the delivery model but they didn't pursue this. In 2009, Medicaid made the decision to implement changes to the Medicaid delivery model in managed care using 1932A State Plan Amendment Authority.
- Medicaid did research and held stakeholder meetings. In Oct 2010, they published an Emergency Rule to start the process. There was a great deal of pushback from providers and the Legislature so, so they had to withdraw it and start over. When the new Secretary arrived (Bruce Greenstein), he began having a series of coordinated care summits throughout the state to talk about changes in the delivery system and to determine ways to make it better. The major changes as a result of the summits were:

    - Implementation of a provider rate floor. MCOs cannot pay providers less than the Medicaid published fee in effect on the date of service. Medicaid is a fast payer and providers were concerned about cash flow. So DHH created a policy to ensure there were not unacceptable interruptions in provider cash flow – 90 percent of claims for each claim type were to be paid within 15 business days and 99 percent within 30 calendar days.
    - There were concerns that money previous going to providers would be spent on something other than healthcare. DHH established an 85 percent medical loss ratio requirement and have a detailed policy on this.
- DHH issued 2 RFPs in April 2011 – one for up to three risk bearing MCOs and one for up to three Medicaid shared savings health plans who LA would pay a monthly fee to do enhanced management of their population, do prior authorizations, and the actual services would continue to be paid FFS. DHH would share any savings that the health plan was able to achieve – 60 percent to the plan and DHH would keep 40 percent. DHH selected two shared savings health plans and the networks only have primary care providers. DHH recommends Alabama not do both models at the same time due to unintended consequences.
- Major decisions to make:
    - Populations to be covered and whether they will be mandatory, voluntary, or totally excluded. You cannot mandate under state plan amendment authority. Children who receive SSI and have special needs, people with Medicare, and the dual eligible population can be mandated with 1915B authority or 1115 waiver authority but not with state plan authority. DHH carved out these populations, or made those that would have required a waiver voluntary.
    - Whether to go with risk bearing MCOs who would be paid a monthly capitation payment and would be at full risk or the PCCM. DHH had 750,000 of their Medicaid population in PCCMs but there was no evidence of management taking place, it was more for a rate increase to primary care providers. There is not enough money to do the kind of management that is needed to make a difference in health outcomes and costs. DHH implemented managed care and PCCM in parallel so providers and members could choose between health plans and models.
- DHH's number one objective was to improve health outcomes. They defined clinical quality measures that they believed were important and tied those improvements in quality to payments. For risk bearing plans, up to 2.5 percent of their payments are at risk if they don't meet the clinical quality measure. For shared savings plan, they have to meet the same quality measures or their savings payout will be decreased.
- Cost is evaluated in the proposal and whether the state establishes the rate in conjunction with the actuary. DHH was more interested in quality improvements and getting health plans that have a proven track record of working with Medicaid populations. Of the risk bearing plans, two of three are the same that were successful in getting contracts awarded in Kentucky – AmeriHealth Mercy and Centene. DHH did not include per member per month in evaluating contracts but

looked at enhanced benefits they would offer to members and providers in scoring the proposals. Plans must continue for the first three years to offer enhanced benefits or incentives to members and providers since this was used in scoring the contracts. DHH selected Centene, AmeriHealth Mercy, and AmeriGroup. DHH expected the coordinated care networks (shared savings plans) would be organic groups of local providers, when in fact, one of the two shared savings plans is United Healthcare and has about 235,000 of the Medicaid population. Community Health Solutions of America provides comparable services under the PCCM model.

- MCOs have flexibility that Medicaid does not have to pay specialist rates that Medicaid cannot pay. Regardless of the cost, MCOs are responsible for getting the care that a person needs and that doesn't always happen in Medicaid. Also there is an incentive for health plans to manage high risk pregnancies. Medicaid does not pay for pain management and has visit limits, such as on Home Health. Prepaid health plans have flexibility that Medicaid does not have. Medicaid cannot get the resources to provide true case management. Medicaid has seen success stories already in case management and interventions to improve health for those with chronic conditions.
- Maternity is in both plans. Incentives of $65 are offered to women who keep all of their prenatal and postpartum visits. 71 percent of births in LA are funded by Medicaid. They have inordinate NICU costs. LA covers pregnant women to 200 percent of the Federal Poverty Level.
- DHH initially carved out pharmacy; however they moved rapidly to add it to the benefits package. Behavioral health services were also carved out because historically, much of the spend was not Medicaid funded so DHH did a separate contract for behavioral health services in order to get rate experience. Dental, long term care and personal care services are also carved out. Consultants advised DHH to first get acute care implemented and stabilized before bringing in long term care.
- The average per member per month, with pharmacy added – with dental, long term care, and behavioral health carved out – is $246.50. DHH has a very complex rate structure. Rates are based on age, gender, Medicaid eligibility group, as well as which of the 9 geographic regions in the state the person resides. There is a wide variation in historic expenditures depending on the geographic area. It is important to incorporate rate adjustment based on risk.
- For the primary care case management model, DHH pays $10.54 per member per month for children and healthy parents; it pays $15.74 for pregnant women and those with disabilities. The plan is expected to provide management of chronic conditions, do prior authorizations, and monitor and provide services for the members.
- Some of the unintended consequences of operating both the MCO and the PCCM at the same time and in the same place:
    - Providers will steer to PCCMs due to incentives and providers can strike better deals for cost sharing. Providers must be paid no less than the Medicaid published rate on the date of service.
    - The sickest members and those with disabilities will stay with the PCCM.

    - Saving projections for the PCCM were less and the actual savings were much less.
- In risk bearing model before pharmacy was added, the actuary took 3 percent off the top so DHH got their savings off the top. Also, Louisiana has a 2.25 percent assessment on MCOs for their membership. So risk bearing plans pay the 2.25 percent assessment to the Department of Insurance and the state is able to use this money for match to draw down additional federal dollars.
- It is critically important to have current provider directories.
- When transitioning from FFS or FFS with light managed care, it is a major realignment of Medicaid administrative staff, both in implementation and ongoing operations.
- DHH recommends pharmacy be included in the core benefit of services. DHH did not at first because of issues with rebates; however, they can now get the advantage of federal rebates and the benefit of greater generic utilization. Without much pushback, the dispensing fee has decreased.
- In regards to transitioning existing members, do not anticipate the members will be ready to choose a plan. It does not matter how much outreach is done and how much money is spent. The majority of the population was auto-assigned. About 70 percent or more of newly enrolled members are proactive about choosing a plan.
- DHH implemented in three phases in close succession – Phase 1 was February 1; Phase 2 was April 1; and Phase 3 was June 1. This took pressure off the contracted enrollment broker because they were not dealing with the entire population at one time.
- DHH suggested:
    - Requesting assistance from CMS' Medicaid State Technical Assistance Teams, who will provide assistance and will expedite getting approval of state plan amendments, waivers, and contracts.
    - Contracting with an external quality review organization. This is not needed until 18 months post implementation; however, they can help with readiness reviews.
    - Have daily provider calls to inform of progress and dispel myths and rumors and allow time for questions. LA has toolbox on two websites: www.makingmedicaidbetter.com (administrative website with contracts and all they've produced) and the other is www.bayouhealth.com (has comparison chart, incentives the five health plans offer, and other materials).

- In hindsight, Louisiana would not run both programs at the same time. They would go with risk bearing plans because there are more savings off the top, they would do managed care provider assessments and get additional match, they would no longer have to pay claims, and the MCO model has flexibility that the others do not have through the federal authority.

OKLAHOMA

Dr. Garth Splinter, Medicaid Director, Oklahoma Health Care Authority

- Oklahoma had commercial managed care years ago, with 6 or 7 companies, but they moved away from it.
- From 1991-1993, there was a statewide effort to look at reform. In 1995, Medicaid transferred from DHS to the Oklahoma Health Care Authority (OHCA).
- OHCA applied for the necessary federal waivers and started managed care in some counties. The rest of the state was under a PCCM model. OHCA used both approaches for about 7 years.
- After having managed care for 7 years, it became clear that the health maintenance organizations (HMOs), or managed care organizations, were not delivering on the basic assumptions that were expected. It appeared that the HMOs were using the same approach that DHS had used and were requesting to put limits on the number of hospital days and physician visits and the number of prescriptions.
- Rather than the HMOs specifying the product, OHCA specified the product and spelled it out in the contract. OHCA had ranges of prices and in the beginning, did not accept all of the bids. Toward the end, it was difficult to get two of the HMOs in each of the market places.
- Given the financial pressures and the way the HMOs were not engaging the restructuring of health delivery, OHCA started internalizing managed care and stopped the purchase of HMO products.
- OHCA took the PCCM model (where they capitated primary care physicians) statewide since they already had it in place. PCCM was rolled into the metropolitan area and over time, OHCA added more pieces of monitoring health and utilization.
- OHCA became the HMO company over time by adding several hundred people whose job was to do all the functional aspects of dealing with members and providers and monitoring outcomes data. OHCA moved to medical homes and used that as the basis for branching out into interventions, tracking, and case management of the highest utilizers. OHCA has an emergency room over-utilization program, a C-section reduction program, etc.
- There are three ways to control costs in Medicaid: (1) modify enrollment so that less people are eligible, (2) modify services covered so that less things are paid for (both of these are under Maintenance of Effort, so states have very little control), and (3) the fee schedule (how much to pay for services that are covered). A fourth is control of utilization, reflected by the PMPM cost. This is what states seek when they move to managed care. This is what OHCA is doing; however, they are doing this internally with their own operating units.
- Oklahoma's Medicaid PMPM, excluding nursing homes and some of the other groups that are considered to be outside of this process, has grown over the last 5 years at about 1.2 percent per year PMPM.
- OHCA has operating groups that include case management, provider relations, and member relations. They also have a large medical group in the agency, as

well as durable medical equipment, pharmacy, and a drug utilization review board.

- OHCA has a medical home system that includes a nurse and dedicated group. The nurse reports to the chief operating officer who reports to the Medicaid director.
- OHCA contracts directly with primary care physicians and pays them a monthly cap plus FFS. When paying FFS, physicians want to do volume because it drives revenue and income. If physicians do purely capitation, everything looks like an expense to the providers and then the agency has to be concerned about under utilization. OHCA chose to blend both FFS and capitation.
- OHCA pays 97 percent of Medicare and pays a monthly PMPM.
- There are three tiers that physicians can select and they are subject to audit. Each level of the tier includes more of the population and includes other things, such as extended hours and outreach. Each of the three tiers have three levels – adults only, children only, or both. The PMPM ranges from $5 to $8 or $9.
- OHCA has 1,800 medical homes and 4.5 thousand physicians.
- OHCA also has three health access networks with only one up and running strongly. They are paid $5 PMPM to provide wrap-around services to the medical homes. The one and two person practices cannot afford to do some of the population based interventions like wellness notices, counseling, behavioral health screenings, etc., so if there are ten practices that need 10 percent of a social worker, one social worker can be put in the health access network and can be responsible for the multiple practices.
- The providers self attested to OHCA on the tiers. OHCA ensured the providers were not overloaded with penalties. As OHCA started performing audits, some providers were dropped in the tiers and some were dropped because they would accept the money without providing services.
- OHCA was able to get specialists into the networks by paying 97 percent of Medicare and by having open communications with the providers. Many states only pay 65-70 percent of Medicare. OHCA also pays an additional 40 percent (for a total of 137 percent of Medicare rate) to medical school providers. CMS allowed a graduate medical education (GME) program for schools and OHCA has several. If a physician in the community is involved in community based medical education in affiliation with a medical school, OHCA pays them 137 percent of Medicare.
- The total funding for the program is $5.3 billion. State match (FMAP) is 64 percent. The state share is $1.5 billion. One billion dollars is appropriated to OHCA and the rest is appropriated to other agencies. Part of the revenue is a hospital assessment that the hospital association agreed to (like a provider tax). OK has a nursing home provider tax and does intergovernmental transfers with other state agencies. The schools pay the state share on the 40 percent paid to them.
- OHCA does something similar to certified public expenditures with the disproportionate share hospitals.

- OHCA does not see itself as an FFS Medicaid agency. It uses FFS like an HMO would use FFS to pay providers. The main focus of the agency is to perform as an HMO would with managed care.
- OHCA has a division of 15 people and a $4 million per year contract with the University of Oklahoma College of Pharmacy where they have a dedicated unit to function as the pharmacy benefits manager. They have a process with drug utilization review where they study and make recommendations to OHCA which they then take to their board through rules or policy changes. They do a lot of prior authorizations in the pharmacy program.
- Consumers are involved in the program. OHCA has 12 external groups, one of which is a consumer group that meets quarterly to provide the feedback of members. They also generate member newsletters.
- Oklahoma Medicaid covers two-thirds of all births in the state (200 percent of the Federal Poverty Level).
- Care for patients with complex health needs is rendered FFS but there is a lot of direct management of these patients through the health access networks.
- Oklahoma Medicaid has 800,000 members. The nursing home population is about 15.5 thousand. The dual eligible population is 108,000. There are 18,000 in the home and community based wavier. Oklahoma Medicaid has interventions for those in nursing homes to be moved back home.
- Due to the combination of the HMOs having savings in the first two years and then asking for higher rates that the Legislature did not want to fund, and the number of HMOs decreasing which, in turn, caused the choices to be limited, Oklahoma moved away from managed care. Oklahoma found that the PCCM model used in the rest of the state saved as much money as they had saved with the HMOs. So, Oklahoma capitated primary care physicians, made them gatekeepers, and they saved as much money.
- OHCA is exempt from merit rules. All employees are unclassified and are at will so they can shift employees around. In the beginning, OHCA was exempt from the purchasing rules so they could get the contracts in place.
- Stability of top management resulted from this design – there is low turn-over in the agency.
- Hospitals are paid on a diagnosis related group basis. Nursing homes are paid a daily rate (about $155 per day). Primary care physicians are paid FFS plus a capitated rate for management. Not including the academic physicians, physicians are paid 97 percent of the Medicare rate plus performance bonuses for certain thresholds and a flat monthly per member rate for general case management. Physicians earn about 102 percent of Medicare when taking other payments into account. Universities earn more, due to the additional 40 percent they are paid.
- If physicians fail, they do not earn the bonus and they are at risk of being decreased in their tier but OHCA does not recoup payments. If physicians are not performing as their contract indicates, their tier is reduced and they can be terminated. OHCA does recoup in the event of fraud (they have a large program integrity group that checks for fraud). The PERM rate (error rate) is the lowest in the nation.

- OHCA pays different management fees, based on the tier of the practice and the population.

OREGON

Commissioner Judy Mohr-Peterson, Division of Medical Assistance, Oregon Health Authority

- Oregon had managed care for 15-20 years but the system was siloed between organizations that did mental health, dental, and physical health care.
- The MCOs were largely community based, not national based entities.
- Oregon had more community based physical health care plans that were built upon the model of an independent practice association (IPA) or a hospital based system.
- The system was not an integrated system. There were strong siloes between the organizations, most strikingly in mental health care. Mental health in Medicaid is very different than the general Medicaid population due to prevalence of mental health issues as well as chronic substance abuse. The siloed systems meant there was no coordination and integration of care.
- The payment system was based on volume. The MCOs managed cost by cutting costs rather than managing the care the best way they could.
- Oregon implemented an 1115 waiver and uses coordinated care organizations (CCOs). The CCO model is basically an accountable care organization (ACO) model.
- CCOs have been in place since August 1, 2012, and the physicians are very excited about the Oregon Medicaid program.
- Within the CCO system, Oregon has incorporated all populations, including the elderly and disabled.
- Long term care is in a separate agency and is not the focus of current efforts.
- CCOs are similar to ACOs because they are a group of providers coming together, they are at financial risk, they include a consumer aspect, and they include substance abuse and mental health providers on the governance board. They are also community based. There are rules and laws around who needs to be on the governing board and they all have to have a consumer advisory council. The body needs to do a health assessment and provide strategic direction on the health improvement plan for the CCO and provide advice on the payment methodology and on the best ways to integrate care. CCOs are similar in that they promote the integration of mental and physical health care. Eventually, it will also involve the incorporation of dental care (in 2014). Currently, the focus is on integration of mental health care and physical health care, which will take a great deal of work.
- CCOs are different from ACOs because ACOs do not carry risk but they have shared savings models. CCOs carry risk and hold risk so they are at full financial risk for all of the care that Oregon is paying them for.
- There is a set amount of money per person and Oregon will hold the growth to a fixed rate over time. The inflation rate fluctuates over time and Oregon will reduce it from 5.4 percent to 4.4 percent to 3.4 percent.
- Oregon must require and promote and provide incentives for the CCOs to contain costs but also maintain quality. This is different from traditional managed

care. Oregon has quality and health outcomes metrics for which the CCOs will be held accountable. Part of the allowable increase over the next few years is taking some of the money and putting it into quality pools for incentives to meet certain benchmarks (starting in January). The quality pool will be increased so that it makes up more and more and the traditional capitation payments will become less and less.

- In summary, Oregon starts with a capitated rate and over time will reduce it and put more of the payment into the risk pool and tie it to quality indicators and outcomes.
- In the system Oregon previously used, the IPAs did not have a good relationship with their hospitals. In the CCO, all of the participants come together in new and different ways. A couple of communities that did not have robust managed care are now working together to look for new and different ways to pay themselves and to promote quality and to integrate care.
- Oregon capitates the payment to the CCOs but the CCOs set the rates to the providers. The CCOs must look for an alternative payment methodology because they do not want a continuation of the FFS model.
- Oregon has two or three strategies related to provider shortage and they are largely related to primary care because there is no shortage of specialists. Oregon is expanding and developing a loan forgiveness program and also promoting the use of non-traditional health care providers (peer wellness specialists, patient navigators, care coordinators, doulas, and nurse practitioners) that can help address some of the critical shortage areas.
- Oregon has 650,000 Medicaid members, the budget for next year is $5 billion, and the match rate is 62 percent.
- A variety of sources are used for the state share of the match for the 1115 waiver, with the primary source being designated state health programs – state funds spent on health care programs that are Medicaid-like services or for a Medicaid-like population. Oregon scoured their state budget for all unmatched state health care programs and included this in the 1115 waiver.
- Oregon had a lot of dollars in the community health program for the indigent population that did not qualify for Medicaid, so they could match a lot of these dollars. Oregon looked at training and educational programs and looked at public health programs that provided direct services to low income populations. They had about $125-200 million per year in unmatched funds in these programs.
- Oregon was not required to commit to expanding its Medicaid program for the 1115 waiver; however, they did have to commit to major health care transformation and reform efforts. They had to commit to not cutting the Medicaid program and had to commit to containing costs by not cutting back on the people or the services. They had to outline how they would use those dollars on health care reform.

TENNESSEE

Darin Gordon, Medicaid Director; and Dr. Wendy Long, Chief Medical Officer, Tennessee Department of Human Services

- Tennessee started using a managed care model on January 1, 1994.
- The model was implemented in six months, which created a lot of issues that the program saw over the next several years.
- Some of the issues were caused by Tennessee allowing any health plan to participate – some had experience in managing care and some did not. Some plans did not meet their contractual obligation and so they became insolvent and failed. When the plans failed, Tennessee reevaluated and rebuilt the program.
- Seven or eight years ago, Tennessee bid out the network over three regions and phased managed care in over a multi-year process. Managed care experience was required.
- Tennessee had previously carved out behavioral care but found they were playing mediator between the health plans and the behavioral health organizations to take care of the same individual. This was unproductive so they integrated behavioral health and was successful.
- Tennessee used two health plans per region.
- A thorough evaluation of the skill sets of staff is required. In some cases, managed care requires a different skill set and requires regulatory oversight functions. In some cases, a state may need to bring in different skill sets.
- The program is doing well. All quality indicators have improved and patient satisfaction is at 95 percent.
- Pharmacy was carved in, then out, and is now moving to a hybrid but the current system is a single formulary. They have a two name brand, five drug limit with some exceptions. Tennessee had one of the highest prescribing rates in the country so they revamped the entire program and their trend rate currently averages one percent or less. Tennessee set the dispensing fee and reimbursement rates and developed the formulary.
- Long term care is now in the networks and the MCOs have control of reimbursement. Tennessee set the rate for nursing facilities using the previous system before managed care and they do the same for home and community based services and set capitated payments. There is an incentive to place more people safely in the home and community based setting. Less than 17 percent of Tennessee's population was receiving home and community based services and in one year's time, this number grew to about 35 percent with no new dollars put into the program. There were aligned incentives, more active engagement at hospital discharge planning, and single ownership of all aspects of the system. Capitated payments are adjusted annually.
- When long term care was added, the contract increased by about 100 pages. Tennessee is very prescriptive in its expectations of the MCOs regarding home and community based services, from how quickly they get out and make home visits to how detailed the care plans must be and how case management must look like. The MCOs submit a lot of different reports that allow Tennessee to

monitor performance. Tennessee staff participates in "ride alongs" to watch the MCOs develop care plans and perform in-home case management. An electronic visit verification system is also used.

- Before long term care was implemented, there was an incentive for the MCOs to recommend patients be sent to nursing facilities because much of their care would no longer be the responsibility of the MCOs. Now, both nursing home care and home and community based services are the responsibility of the MCOs, so the MCOs are more inclined to keep the patients at home, rather than send him/her to a nursing home.
- Tennessee has a variety of mechanisms for consumer involvement. There are regular meetings with a wide variety of advocacy organizations, usually monthly, to get feedback and to keep them informed.
- At one point, Tennessee did not have a medically needy program outside of pregnant women and children. A small amount of state dollars became available to open a medically needy program but in order to stay within the budget, there is a sort of lottery system, where the program is opened by phone every quarter and Tennessee can enroll as many people as they can afford in the quarter.
- The MCO contracts are typically three years with two optional one year extensions. Tennessee is attempting to extend the contracts to a longer time frame (possibly 7 years) because it takes a while for the MCOs to make money on the contract. New MCOs typically lose money during the first year.
- Tennessee's system is constructed so that services are not reduced and access is not limited. It is important to have a clear definition of medical necessity and guidelines for the MCOs to follow.
- The provider incentives are appropriately aligned and provider networks are adequate. The primary care physician networks are very strong. Tennessee is a rural state so everyone cannot always access specialty care as close to home as they would like; however, Tennessee provides transportation benefits when they need to bring members to a certain area for specialized care.
- Tennessee has 91 percent provider participation in their MCOs.
- The rates that are paid to doctors and hospitals are negotiated with the MCOs. Long term care rates are established by Tennessee.
- Tennessee suggests letting competitive bids and using qualified health plans with a good quality track record; developing a very detailed contract and focusing as much on quality as fiscal issues in the contract; assuring that the Medicaid agency is staffed and prepared to shift gears to monitor the MCOs; and using regional coverage areas and implementing region by region for a smooth transition.